		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037655

Facility Name: Fairview Nursing Plaza Inc.

Address: 321 Arnold Ave . (Number) Rockford (City) 61108 (Zip Code)

County: Winnebago

Telephone Number: (815) 397-5531 **Fax #** (815) 397-7629

IDPA ID Number: 363782675001

Date of Initial License for Current Owners: 09/01/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,724	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,536	779	2,572	22,887	8
9	SNF/PED					9
10	ICF	43,700	1,742	191	45,633	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,236	2,521	2,763	68,520	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.89%

D. How many bed-hold days during this year were paid by Public Aid? 509 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,939

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	195,625	34,471	34,932	265,028		265,028	(20,414)	244,614			1
2	Food Purchase		338,619		338,619	(19,856)	318,764	(124)	318,639			2
3	Housekeeping	161,097	27,667		188,764		188,764	662	189,426			3
4	Laundry	81,369	30,042		111,411		111,411		111,411			4
5	Heat and Other Utilities			141,318	141,318		141,318	2,278	143,596			5
6	Maintenance	46,251	25,473	107,901	179,625		179,625	(34,525)	145,100			6
7	Other (specify):*							4,022	4,022			7
8	**TOTAL General Services**	484,342	456,272	284,151	1,224,765	(19,856)	1,204,910	(48,101)	1,156,808			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,825,263	108,374	265,950	2,199,587		2,199,587	(34,489)	2,165,098			10
10a	Therapy	45,362	6,766	18,628	70,756		70,756	(3,871)	66,885			10a
11	Activities	112,396	14,057	2,267	128,720		128,720		128,720			11
12	Social Services	164,840		11,225	176,065		176,065		176,065			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,574	4,574			15
16	**TOTAL Health Care and Programs**	2,147,861	129,197	305,270	2,582,328		2,582,328	(33,786)	2,548,542			16
	C. General Administration											
17	Administrative	112,701		79,056	191,757		191,757	(4,961)	186,796			17
18	Directors Fees											18
19	Professional Services			146,030	146,030	(133)	145,897	(108,234)	37,663			19
20	Dues, Fees, Subscriptions & Promotions			28,860	28,860		28,860	(8,236)	20,624			20
21	Clerical & General Office Expenses	151,914	23,272	174,737	349,923		349,923	(106,986)	242,937			21
22	Employee Benefits & Payroll Taxes			396,911	396,911	19,856	416,767	(663)	416,104			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,033	5,033		5,033	473	5,506			24
25	Other Admin. Staff Transportation			5,819	5,819		5,819	2,721	8,540			25
26	Insurance-Prop.Liab.Malpractice			157,523	157,523		157,523	1,095	158,618			26
27	Other (specify):*							21,515	21,515			27
28	**TOTAL General Administration**	264,615	23,272	993,969	1,281,856	19,723	1,301,579	(203,276)	1,098,303			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,896,818	608,741	1,583,390	5,088,949	(133)	5,088,816	(285,164)	4,803,652			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairview Nursing Plaza Inc. #0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,965	51,965		51,965	21,004	72,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,917	85,917		85,917	703	86,620			32
33	Real Estate Taxes			89,570	89,570	133	89,703	6,292	95,995			33
34	Rent-Facility & Grounds			598,309	598,309		598,309		598,309			34
35	Rent-Equipment & Vehicles			6,844	6,844		6,844	3,808	10,652			35
36	Other (specify):*											36
37	**TOTAL Ownership**			832,605	832,605	133	832,738	31,807	864,545			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,828	158,660	235,488		235,488		235,488			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,938	116,938		116,938		116,938			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		76,828	275,598	352,426		352,426		352,426			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,896,818	685,569	2,691,593	6,273,980		6,273,980	(253,356)	6,020,624			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,243	30		9
10	Interest and Other Investment Income	(575)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,009)	21		24
25	Fund Raising, Advertising and Promotional	(2,913)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,893)	20		28
29	Other-Attach Schedule	(32,231)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,852)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,504)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (76,504)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (253,356)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Fairview Nursing Plaza Inc.

IDE 0037655

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VA Expenses	$ (1,194)	10	1
2	Theft & Damage	(1,831)	21	2
3	Trust Fees	(200)	20	3
4	IL Council on LTC - COPE	(3,296)	20	4
5	Capitalized R&M	(22,365)	06	5
6	Non-Allowable Legal	(3,323)	19	6
7	Misc. Income	(22)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(32,231)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(15,254)	(5,160)						(20,414)	1
2	Food Purchase	(124)											(124)	2
3	Housekeeping			662									662	3
4	Laundry													4
5	Heat and Other Utilities			867	1,411								2,278	5
6	Maintenance	(22,365)		632	(12,757)		(35)						(34,525)	6
7	Other (specify):*				957	1,358	1,707						4,022	7
8	**TOTAL General Services**	(22,489)		2,161	(10,389)	(13,896)	(3,488)						(48,101)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,194)			(24,214)				(9,081)				(34,489)	10
10a	Therapy						(3,871)						(3,871)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,403		1,171						4,574	15
16	**TOTAL Health Care and Programs**	(1,194)			(20,811)		(2,700)		(9,081)				(33,786)	16
	C. General Administration													
17	Administrative			17,010	(65,121)	47,470	(4,320)						(4,961)	17
18	Directors Fees													18
19	Professional Services	(3,323)		(101,806)	327	13,824	(17,256)						(108,234)	19
20	Fees, Subscriptions & Promotions	(8,652)		208	208								(8,236)	20
21	Clerical & General Office Expenses	(156,862)		58,684	(8,808)								(106,986)	21
22	Employee Benefits & Payroll Taxes							(663)					(663)	22
23	Inservice Training & Education													23
24	Travel and Seminar			166	307								473	24
25	Other Admin. Staff Transportation			572	2,149								2,721	25
26	Insurance-Prop.Liab.Malpractice			415	680								1,095	26
27	Other (specify):*			10,055	4,010	7,450							21,515	27
28	**TOTAL General Administration**	(168,837)		(14,696)	(66,248)	68,744	(21,576)	(663)					(203,276)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(192,520)		(12,535)	(97,448)	54,848	(27,764)	(663)	(9,081)				(285,164)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	**16,243**		**2,049**	**2,712**								**21,004**	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	**(575)**		**371**	**907**								**703**	32
33	Real Estate Taxes			**2,233**	**4,059**								**6,292**	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			**2,153**	**1,655**								**3,808**	35
36	Other (specify):*													36
37	**TOTAL Ownership**	**15,668**		**6,806**	**9,333**								**31,807**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(176,852)**		**(5,729)**	**(88,115)**	**54,848**	**(27,764)**	**(663)**	**(9,081)**				**(253,356)**	45

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 662	$ 662	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	867	867	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	632	632	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,010	17,010	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,374	1,374	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	208	208	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	58,684	58,684	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	166	166	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	572	572	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	415	415	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,055	10,055	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,049	2,049	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	371	371	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,233	2,233	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,153	2,153	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	103,180	PREFERRED BOOKKEEPING	100.00%		(103,180)	32
33	V	19	COMPUTER	5,112	PREFERRED BOOKKEEPING	100.00%	5,112		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 108,292			$ 102,563	$ * (5,729)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,411	$ 1,411	15
16	V	6	REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	6,419	(12,757)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	957	957	17
18	V	10	NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	17,966	(24,214)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,403	3,403	19
20	V	17	ADMINISTRATIVE	74,736	S.I.R. MANAGEMENT, INC.	100.00%	9,615	(65,121)	20
21	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	327	327	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	208	208	22
23	V	21	CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	12,924	(8,808)	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	307	307	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,149	2,149	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	680	680	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,010	4,010	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,712	2,712	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	907	907	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,059	4,059	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,655	1,655	31
32	V								32
33	V	39	LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V								36
37	V								37
38	V								38
39	Total			$ 157,824			$ 69,709	$ * (88,115)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 21,732	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,478	$ (15,254)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,358	1,358	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	47,470	47,470	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,824	13,824	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,450	7,450	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,732			$ 76,580	$ * 54,848	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	SPECIAL REHAB	9,456	S.I.R. MANAGEMENT, INC.	100.00%	5,585	$ (3,871)	15
16	V	15	EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,171	1,171	16
17	V								17
18	V	6	REPAIRS AND MAINT.	144	S.I.R. MANAGEMENT, INC.	100.00%	109	(35)	18
19	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	22	22	19
20	V								20
21	V								21
22	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	8,040	(5,160)	22
23	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,685	1,685	23
24	V								24
25	V	19	LEGAL FEES	17,256	S.I.R. MANAGEMENT, INC.	100.00%		(17,256)	25
26	V								26
27	V	17	FEES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,376			$ 16,612	$ * (27,764)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 122,144	$ 122,144	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	122,807	CCS EMPLOYEE BENEFIT GROUP	100.00%		(122,807)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 122,807			$ 122,144	$ * (663)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	61,211	XCEL MEDICAL SUPPLY, LLC	100.00%	52,130	(9,081)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,211			$ 52,130	$ * (9,081)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Solomon	Owner	Administrator	6.58%	None	40.00	100.00%	Salary	$ 90,233	17-1	1
2	Tom Winter	Owner	Administrative	0.88%	See Attached	6.31	10.52%	Alloc. Salary	17,010	17-7	2
3	Louise Bergthold	Owner	Administrative	2.63%	See Attached	5.55	10.09%	Alloc. Salary	17,753	17-7	3
4	Nenita Guzman	Relative	Dietary		See Attached	5.05	10.10%	Alloc. Salary	6,478	1-7	4
5	Eric Rothner	Relative	Administrative		See Attached	0.78	1.69%	Alloc. Salary	9,494	17-7	5
6	Adam Vales	Relative	Clerical		See Attached	0.80	2.00%	Alloc. Salary	824	22-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 141,792		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	927,958	10	$ 5,955	$	103,180	$ 662	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801		103,180	867	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680		103,180	632	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	152,983	103,180	17,010	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360		103,180	1,374	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874		103,180	208	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	466,233	103,180	58,684	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493		103,180	166	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142		103,180	572	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729		103,180	415	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428		103,180	10,055	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431		103,180	2,049	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338		103,180	371	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087		103,180	2,233	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368		103,180	2,153	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,112	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 876,446	$ 619,216		$ 102,563	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	678,909	11	$ 13,981	$	68,520	$ 1,411	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606	46,253	68,520	6,419	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		68,520	957	3
4	10	NURSING	PATIENT DAYS	678,909	11	178,013	178,013	68,520	17,966	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		68,520	3,403	5
6	17	ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	68,520	9,615	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		68,520	327	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		68,520	208	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	68,520	12,924	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		68,520	307	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		68,520	2,149	11
12	26	INSURANCE	PATIENT DAYS	678,909	11	6,736		68,520	680	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		68,520	4,010	13
14	30	DEPRECIATION	PATIENT DAYS	678,909	11	26,873		68,520	2,712	14
15	32	INTEREST	PATIENT DAYS	678,909	11	8,988		68,520	907	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		68,520	4,059	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		68,520	1,655	17
18										18
19	39	LEASED EQUIPMENT	LEASING INCOME	52,560	1					19
20	30	DEPRECIATION	LEASING INCOME	52,560	1	24,293				20
21	32	INTEREST	LEASING INCOME	52,560	1	6,298				21
22										22
23										23
24										24
25	TOTALS					$ 721,298	$ 410,443		$ 69,709	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	678,909	11	$ 64,183	$ 64,183	68,520	$ 6,478	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453		68,520	1,358	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	470,339	68,520	47,470	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972		68,520	13,824	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815		68,520	7,450	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406			7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	30	4	1,462				8
9	21	CLERICAL & GEN.-B. BARRISI	AVG HRS WKD	30	4	1,426				9
10	26	AUTO INSURANCE-B. BARRISI	AVG HRS WKD	30	4	733				10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115				11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634				12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673			14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	560				15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	726				16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946				17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,157,199	$ 840,601		$ 76,580	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	$ 63,630	$ 63,630	9,456	$ 5,585	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337		9,456	1,171	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	144	109	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		144	22	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	13,200	8,040	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		13,200	1,685	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 298,589	$ 247,873		$ 16,612	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 122,144	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 122,144	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation							3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						52,130	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 52,130	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	CIB Bank		X	Line of Credit		06/20/03		1,880,000		5.2500	85,917	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 1,880,000			$ 85,917	9
	B. Non-Facility Related*											
10	Interest Income		X								(575)	10
11	Alloc. Preferred Bookkeeping		X								371	11
12	Alloc. SIR Management		X								907	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 703	14
15	TOTALS (line 9+line14)						$	$ 1,880,000			$ 86,620	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	90,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	95,262	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,662	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	91,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	133	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	95,995	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	102,486	8
	2000	101,225	9
	2001	86,094	10
	2002	88,240	11
	2003	88,970	12

2004 Accrual = $88,970 X 1.025 = $91,200

Preferred Bookkeeping Allocation $2,233

SIR Management Allocation $4,059

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-28-203-0004	Long Term Care Property	$ 88,969.66	$ 88,969.66
2.	See Attached	See Attached	$ 79,702.01	$ 5,883.78
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 168,671.67	$ 94,853.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,808 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	55,434		20	2,772	2,772	34,860	9
10	Various			1993	68,424		20	3,421	3,421	38,870	10
11	Various			1994	44,837		20	2,242	2,242	24,334	11
12	Various			1995	14,482		20	724	(724)	6,573	12
13	Various			1996	9,472		20	574	574	4,804	13
14	Various			1997	73,164		20	3,658	3,658	27,917	14
15	Various			1998	23,867		20	1,436	1,436	8,868	15
16	Various			1999	58,600		20	2,930	2,930	15,993	16
17	Various			2000	50,948		20	2,547	2,547	10,876	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		84,546	2,877		3,327	450	31,741	68
69	Financial Statement Depreciation			51,964			(51,964)		69
70	TOTAL (lines 4 thru 69)		$ 483,774	$ 54,841		$ 23,631	$ (32,658)	$ 204,836	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 483,774	$ 54,841		$ 23,631	$ (31,210)	$ 204,836	1
2	Painting	2001	7,000		20	350	350	1,371	2
3	Elevator Work	2001	11,945		20	597	597	2,339	3
4	Hvac Work	2001	4,148		20	207	207	743	4
5	Water Heater	2001	9,438		20	472	472	1,534	5
6	Carpeting	2001	3,845		20	192	192	609	6
7	Freezer Compressor	2001	2,101		20	105	105	420	7
8	Freezer Work	2001	1,561		20	78	78	299	8
9	Heater Repair	2001	2,207		20	110	110	340	9
10	Patio Light	2001	1,302		20	65	65	211	10
11	Door Replacement	2002	2,298		20	460	460	1,226	11
12	Mini Blinds	2002	1,014		20	101	101	262	12
13	Hvac	2002	20,225		20	2,023	2,023	4,214	13
14	Water Heater	2002	4,993		20	499	499	1,456	14
15	Greast Trap	2002	3,181		20	318	318	689	15
16	Roof	2002	800		20	80	80	240	16
17	Drywall	2002	3,150		20	315	315	919	17
18	Storeroom Door	2002	1,168		20	117	117	311	18
19	Sidewalk/Landscaping	2002	1,675		20	112	112	288	19
20	Nurses Station Counter	2002	610		20	61	61	137	20
21	Bath Wall	2003	1,950		20	98	98	179	21
22	Bath Wall	2003	2,700		20	135	135	248	22
23	Kitchen Wall	2003	1,450		20	73	73	133	23
24	Elevator Door	2003	1,545		20	77	77	142	24
25	Parking Lot Work	2003	3,960		20	198	198	314	25
26	Bath Wall	2003	1,900		20	95	95	150	26
27	Medication Room	2003	1,200		20	60	60	90	27
28	Shower Room	2003	2,400		20	120	120	150	28
29	Bath Wall	2003	1,200		20	60	60	75	29
30	Shower Room	2003	2,800		20	140	140	163	30
31	Bi-Fold Doors	2003	1,267		20	63	63	127	31
32	Burners & Wall Thermostat	2003	1,847		20	92	92	185	32
33	Doors	2003	1,747		20	87	87	167	33
34	TOTAL (lines 1 thru 33)		$ 592,401	$ 54,841		$ 31,191	$ (23,650)	$ 224,567	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 592,401	$ 54,841		$ 31,191	$ (23,650)	$ 224,567	1
2	Extra Large Mini Blinds	2003	1,003		20	50	50	92	2
3	Grout Dishwashing Area	2003	550		20	28	28	44	3
4	Replace Blower Wheels & Bearings	2003	1,659		20	83	83	124	4
5	Solid Core Birch Doors	2003	1,061		20	53	53	75	5
6	1" Mini Blinds	2003	1,003		20	50	50	63	6
7	Flooring	2004	138,715		20	5,202	5,202	5,202	7
8	Carpeting*	2004	3,538		20	44	44	44	8
9	Bi-Fold Doors*	2004	1,109		20	111	111	111	9
10	Water Lines To Washing Machine*	2004	1,021		20	102	102	102	10
11	Remodel Shower Room*	2004	2,850		20	285	285	285	11
12	Electrical Repair*	2004	2,309		20	231	231	231	12
13	Electrical Repair*	2004	2,659		20	266	266	266	13
14	Elevator Repair*	2004	1,683		20	168	168	168	14
15	Generator Room Repair*	2004	1,574		20	157	157	157	15
16	A/C Repair*	2004	1,171		20	117	117	117	16
17	Miniblinds*	2004	1,002		20	100	100	100	17
18	Repair Asphalt*	2004	1,200		20	120	120	120	18
19	Repair Medical Records Floor*	2004	750		20	75	75	75	19
20	New Heat Exchanger - Hvac*	2004	2,436		20	244	244	244	20
21	Remodel Shower Room*	2004	2,600		20	260	260	260	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 762,295	$ 54,841		$ 38,937	$ (15,904)	$ 232,447	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR		1993		$ 14,839	$ 471	35	$ 424	$ (47)	$ 4,875	4
5	SIR		1993		26,969	856	35	771	(85)	8,861	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1997	18,531	415	20	927	512	7,236	9
10	Preferred Bookkeeping - Allocation			1999	147	-	20	7	7	40	10
11	Preferred Bookkeeping - Allocation			2000	929	-	20	46	46	205	11
12											12
13	SIR Properties - Preferred Bookkeeping - Allocation			2002	59	-	20	3	3	7	13
14	SIR Properties - Preferred Bookkeeping - Allocation			1999	1,880	188	20	94	(94)	517	14
15	SIR Properties - Preferred Bookkeeping - Allocation			1998	899	90	20	45	(45)	292	15
16	SIR Properties - Preferred Bookkeeping - Allocation			1997	56	6	20	3	(3)	24	16
17	SIR Properties - Preferred Bookkeeping - Allocation			1994	141	4	20	7	3	74	17
18	SIR Properties - Preferred Bookkeeping - Allocation			1993	241	1	20	12	11	138	18
19											19
20	SIR Properties - SIR Management - Allocation			2002	107	-	20	5	5	13	20
21	SIR Properties - SIR Management - Allocation			1999	3,417	342	20	171	(171)	940	21
22	SIR Properties - SIR Management - Allocation			1998	1,633	163	20	82	(81)	531	22
23	SIR Properties - SIR Management - Allocation			1997	102	10	20	5	(5)	43	23
24	SIR Properties - SIR Management - Allocation			1994	257	7	20	13	6	135	24
25	SIR Properties - SIR Management - Allocation			1993	437	2	20	22	20	252	25
26											26
27	SIR Management - Allocation			1993	11,583	322	20	574	252	6,891	27
28				1994	36	-	20	2	2	36	28
29				1995	265	-	20	13	13	125	29
30				1999	1,258	-	20	63	63	328	30
31				2000	760	-	20	38	38	178	31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 84,546	$ 2,877		$ 3,327	$ 450	$ 31,741	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 334,315	$ 1,766	$ 27,706	$ 25,940	10	$ 232,427	71
72	Current Year Purchases	78,651	119	6,326	6,207	10	6,326	72
73	Fully Depreciated Assets	112,161				10	112,161	73
74								74
75	TOTALS	$ 525,127	$ 1,885	$ 34,032	$ 32,147		$ 350,914	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CHEVY VAN	1996	$ 11,516	$	$	$	5	$ 11,516	76
77										77
78										78
79										79
80	TOTALS			$ 11,516	$	$	$		$ 11,516	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,298,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,726	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,969	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,243	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 594,877	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Briar Glen Partnership

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		213		$ 598,309			3
4	Additions							4
5								5
6								6
7	TOTAL		213		$ 598,309 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 02/1996
Ending 09/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 874,631
13.	/2006	$ 874,631
14.	/2007	$ 874,631

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 10,652 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 78,792	$		$ 78,792	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			29			29	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			79,839			79,839	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				51,318		51,318	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						25,510		25,510	13
14	TOTAL			$		$ 158,660	$ 76,828		$ 235,488	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. **#** 0037655 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,135	$	1
2	Cash-Patient Deposits	41,663		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,470,472		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,154		6
7	Other Prepaid Expenses	2,693		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	10,899		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,548,016	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	396,622		15
16	Equipment, at Historical Cost	613,117		16
17	Accumulated Depreciation (book methods)	(590,897)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,938		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 420,780	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,968,796	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 397,603	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,948		28
29	Short-Term Notes Payable	1,880,000		29
30	Accrued Salaries Payable	141,216		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,020		31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,200		32
33	Accrued Interest Payable	2,811		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	443		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,574,241	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,574,241	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (605,445)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,968,796	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (612,729)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (612,729)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,284	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 7,284	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (605,445)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,771,387	1
2	Discounts and Allowances for all Levels	(17,750)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,753,637	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	454,820	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 454,820	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,655	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,784	19
20	Radiology and X-Ray	1,746	20
21	Other Medical Services	4,659	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 58,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	575	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 575	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,388	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,388	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,281,264	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,224,765	31
32	Health Care	2,582,328	32
33	General Administration	1,281,856	33
	B. Capital Expense		
34	Ownership	832,605	34
	C. Ancillary Expense		
35	Special Cost Centers	235,488	35
36	Provider Participation Fee	116,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,273,980	40
41	**Income before Income Taxes (line 30 minus line 40)****	7,284	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 7,284	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,989	2,260	$ 68,132	$ 30.15	1
2	Assistant Director of Nursing	1,906	2,115	49,716	23.51	2
3	Registered Nurses	11,016	11,741	238,160	20.28	3
4	Licensed Practical Nurses	21,480	23,061	460,859	19.98	4
5	Nurse Aides & Orderlies	78,471	83,951	915,901	10.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,867	4,158	45,362	10.91	8
9	Activity Director	1,975	2,091	26,867	12.85	9
10	Activity Assistants	11,083	11,670	85,529	7.33	10
11	Social Service Workers	14,753	15,482	164,840	10.65	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,091	31,125	14.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,315	22,628	164,500	7.27	15
16	Dishwashers					16
17	Maintenance Workers	3,887	4,205	46,251	11.00	17
18	Housekeepers	20,489	21,595	161,097	7.46	18
19	Laundry	10,212	11,270	81,369	7.22	19
20	Administrator	1,881	2,091	90,233	43.15	20
21	Assistant Administrator	1,347	1,584	22,468	14.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,016	11,856	151,914	12.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,946	5,264	92,495	17.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	223,603	239,113	$ 2,896,818 *	$ 12.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,200	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,180	10-03	38
39	Pharmacist Consultant	Monthly	3,834	10-03	39
40	Physical Therapy Consultant	126	6,664	10a-03	40
41	Occupational Therapy Consultant	43	2,508	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,267	11-03	44
45	Social Service Consultant	94	5,225	12-03	45
46	Other(specify) Dir of Food Service	Monthly	21,732	01-03	46
47	Psycho/Social Consultant	Monthly	6,000	12-03	47
48	Rehab Consultant	Monthly	9,456	10a-03	48
49	TOTAL (lines 35 - 48)	310	$ 120,266		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	239	$ 9,045	10-03	50
51	Licensed Practical Nurses	4,685	155,031	10-03	51
52	Nurse Aides	3,246	55,860	10-03	52
53	TOTAL (lines 50 - 52)	8,170	$ 219,936		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon	Administrator	6.58	$ 90,233
Christopher Tritt	Asst Admin	0	22,468
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,701

B. Administrative - Other

Description	Amount
SIR Management, Inc. - Fees	$ 4,320
SIR Management, Inc. - Ancillary Admin. Charges	47,892
SIR Management, Inc. - Director of Admin. Services	26,844
TOTAL (agree to Schedule V, line 17, col. 3)	$ 79,056
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 14,145
Preferred Bookkeeping	Accounting	26,500
SIR Management	Regulatory Consultant	17,256
Preferred Bookkeeping	Bookkeeping	76,680
Personnel Planners	Unemployment Consultant	1,485
LTC Solutions	Computer Services	1,320
ICS Solutions	Computer Services	209
Preferred Bookkeeping	Computer Consultant	5,112
Stuart Sikes	Legal (Adj. on P. 5)	45
Rock County Sheriff's Dept	Legal (Adj. on P. 5)	83
Michael Best & Friedrich	Legal (Adj. on P. 5)	3,195
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 146,030

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,239
Unemployment Compensation Insurance	72,858
FICA Taxes	215,078
Employee Health Insurance	71,166
Employee Meals	19,856
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	2,254
Other Employee Benefits	8,653
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,104

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,341
Health Care Worker Background Check	807
(Indicate # of checks performed 67)	
Licenses and Permits	520
IL Council on LTC	6,538
Dues and Subscriptions	2,002
Alloc. Preferred Bookkeeping	208
Alloc. S.I.R. Management	208
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,033
Alloc. Preferred Bookkeeping	166
Alloc. S.I.R. Management	307
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,506

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council - $9,834**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,877** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **116,938**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,856** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.